§ 438.66 State monitoring requirements.

(a) *General requirement.* The State agency must have in effect a monitoring system for all managed care programs.

(b) The State's system must address all aspects of the managed care program, including the performance of each MCO, PIHP, PAHP, and PCCM entity (if applicable) in at least the following areas:

(1) Administration and management.

(2) Appeal and grievance systems.

(3) Claims management.

(4) Enrollee materials and customer services, including the activities of the beneficiary support system.

(5) Finance, including medical loss ratio reporting.

(6) Information systems, including encounter data reporting.

(7) Marketing.

(8) Medical management, including utilization management and case management.

(9) Program integrity.

(10) Provider network management, including provider directory standards.

(11) Availability and accessibility of services, including network adequacy standards.

(12) Quality improvement.

(13) Areas related to the delivery of LTSS not otherwise included in paragraphs (b)(1) through (12) of this section as applicable to the managed care program.

(14) All other provisions of the contract, as appropriate.

(c) The State must use data collected from its monitoring activities to improve the performance of its managed care program, including at a minimum:

(1) Enrollment and disenrollment trends in each MCO, PIHP, or PAHP.

(2) Member grievance and appeal logs.

(3) Provider complaint and appeal logs.

(4) Findings from the State's External Quality Review process.

(5) Results from any enrollee or provider satisfaction survey conducted by the State or MCO, PIHP, or PAHP.

(6) Performance on required quality measures.

(7) Medical management committee reports and minutes.

(8) The annual quality improvement plan for each MCO, PIHP, PAHP, or PCCM entity.

(9) Audited financial and encounter data submitted by each MCO, PIHP, or PAHP.

(10) The medical loss ratio summary reports required by § 438.8.

(11) Customer service performance data submitted by each MCO, PIHP, or PAHP and performance data submitted by the beneficiary support system.

(12) Any other data related to the provision of LTSS not otherwise included in paragraphs (c)(1) through (11) of this section as applicable to the managed care program.

(d)(1) The State must assess the readiness of each MCO, PIHP, PAHP or PCCM entity with which it contracts as follows:

(i) Prior to the State implementing a managed care program, whether the program is voluntary or mandatory.

(ii) When the specific MCO, PIHP, PAHP, or PCCM entity has not previously contracted with the State.

(iii) When any MCO, PIHP, PAHP, or PCCM entity currently contracting with the State will provide or arrange for the provision of covered benefits to new eligibility groups.

(2) The State must conduct a readiness review of each MCO, PIHP, PAHP, or PCCM entity with which it contracts as follows:

(i) Started at least 3 months prior to the effective date of the events described in paragraph (d)(1) of this section.

(ii) Completed in sufficient time to ensure smooth implementation of an event described in paragraph (d)(1) of this section.

(iii) Submitted to CMS for CMS to make a determination that the contract or contract amendment associated with an event described in paragraph (d)(1) of this section is approved under § 438.3(a).

(3) Readiness reviews described in paragraphs (d)(1)(i) and (ii) of this section must include both a desk review of documents and on-site reviews of each MCO, PIHP, PAHP, or PCCM entity. Readiness reviews described in paragraph (d)(1)(iii) of this section must include a desk review of documents and may, at the State's option, include an

on-site review. On-site reviews must include interviews with MCO, PIHP, PAHP, or PCCM entity staff and leadership that manage key operational areas.

(4) A State's readiness review must assess the ability and capacity of the MCO, PIHP, PAHP, and PCCM entity (if applicable) to perform satisfactorily for the following areas:

(i) Operations/Administration, including—

(A) Administrative staffing and resources.

(B) Delegation and oversight of MCO, PIHP, PAHP or PCCM entity responsibilities.

(C) Enrollee and provider communications.

(D) Grievance and appeals.

(E) Member services and outreach.

(F) Provider Network Management.

(G) Program Integrity/Compliance.

(ii) Service delivery, including—

(A) Case management/care coordination/service planning.

(B) Quality improvement.

(C) Utilization review.

(iii) Financial management, including—

(A) Financial reporting and monitoring.

(B) Financial solvency.

(iv) Systems management, including—

(A) Claims management.

(B) Encounter data and enrollment information management.

(e)(1) The State must submit to CMS no later than 180 days after each contract year, a report on each managed care program administered by the State, regardless of the authority under which the program operates.

(i) The initial report will be due after the contract year following the release of CMS guidance on the content and form of the report.

(ii) For States that operate their managed care program under section 1115(a) of the Act authority, submission of an annual report that may be required by the Special Terms and Conditions of the section 1115(a) demonstration program will be deemed to satisfy the requirement of this paragraph (e)(1) provided that the report includes the information specified in paragraph (e)(2) of this section.

(2) The program report must provide information on and an assessment of the operation of the managed care program on, at a minimum, the following areas:

(i) Financial performance of each MCO, PIHP, and PAHP, including MLR experience.

(ii) Encounter data reporting by each MCO, PIHP, or PAHP.

(iii) Enrollment and service area expansion (if applicable) of each MCO, PIHP, PAHP, and PCCM entity.

(iv) Modifications to, and implementation of, MCO, PIHP, or PAHP benefits covered under the contract with the State.

(v) Grievance, appeals, and State fair hearings for the managed care program.

(vi) Availability and accessibility of covered services within the MCO, PIHP, or PAHP contracts, including network adequacy standards.

(vii) Evaluation of MCO, PIHP, or PAHP performance on quality measures, including as applicable, consumer report card, surveys, or other reasonable measures of performance.

(viii) Results of any sanctions or corrective action plans imposed by the State or other formal or informal intervention with a contracted MCO, PIHP, PAHP, or PCCM entity to improve performance.

(ix) Activities and performance of the beneficiary support system.

(x) Any other factors in the delivery of LTSS not otherwise addressed in (e)(2)(i)–(ix) of this section as applicable.

(3) The program report required in this section must be:

(i) Posted on the Web site required under § 438.10(c)(3).

(ii) Provided to the Medical Care Advisory Committee, required under § 431.12 of this chapter.

(iii) Provided to the stakeholder consultation group specified in § 438.70, to the extent that the managed care program includes LTSS.

(f) *Applicability.* States will not be held out of compliance with the requirements of paragraphs (a) through (d) of this section prior to the rating period for contracts starting on or after July 1, 2017, so long as they comply with the corresponding standard(s)

codified in 42 CFR 438.66 contained in the 42 CFR, parts 430 to 481, edition revised as of October 1, 2015.

§ 438.68 Network adequacy standards.

(a) *General rule.* A State that contracts with an MCO, PIHP or PAHP to deliver Medicaid services must develop and enforce network adequacy standards consistent with this section.

(b) *Provider-specific network adequacy standards.* (1) At a minimum, a State must develop time and distance standards for the following provider types, if covered under the contract:

(i) Primary care, adult and pediatric.

(ii) OB/GYN.

(iii) Behavioral health (mental health and substance use disorder), adult and pediatric.

(iv) Specialist, adult and pediatric.

(v) Hospital.

(vi) Pharmacy.

(vii) Pediatric dental.

(viii) Additional provider types when it promotes the objectives of the Medicaid program, as determined by CMS, for the provider type to be subject to time and distance access standards.

(2) *LTSS.* States with MCO, PIHP or PAHP contracts which cover LTSS must develop:

(i) Time and distance standards for LTSS provider types in which an enrollee must travel to the provider to receive services; and

(ii) Network adequacy standards other than time and distance standards for LTSS provider types that travel to the enrollee to deliver services.

(3) *Scope of network adequacy standards.* Network standards established in accordance with paragraphs (b)(1) and (2) of this section must include all geographic areas covered by the managed care program or, if applicable, the contract between the State and the MCO, PIHP or PAHP. States are permitted to have varying standards for the same provider type based on geographic areas.

(c) *Development of network adequacy standards.* (1) States developing network adequacy standards consistent with paragraph (b)(1) of this section must consider, at a minimum, the following elements:

(i) The anticipated Medicaid enrollment.

(ii) The expected utilization of services.

(iii) The characteristics and health care needs of specific Medicaid populations covered in the MCO, PIHP, and PAHP contract.

(iv) The numbers and types (in terms of training, experience, and specialization) of network providers required to furnish the contracted Medicaid services.

(v) The numbers of network providers who are not accepting new Medicaid patients.

(vi) The geographic location of network providers and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees.

(vii) The ability of network providers to communicate with limited English proficient enrollees in their preferred language.

(viii) The ability of network providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid enrollees with physical or mental disabilities.

(ix) The availability of triage lines or screening systems, as well as the use of telemedicine, e-visits, and/or other evolving and innovative technological solutions.

(2) States developing standards consistent with paragraph (b)(2) of this section must consider the following:

(i) All elements in paragraphs (c)(1)(i) through (ix) of this section.

(ii) Elements that would support an enrollee's choice of provider.

(iii) Strategies that would ensure the health and welfare of the enrollee and support community integration of the enrollee.

(iv) Other considerations that are in the best interest of the enrollees that need LTSS.

(d) *Exceptions process.* (1) To the extent the State permits an exception to any of the provider-specific network standards developed under this section, the standard by which the exception will be evaluated and approved must be:

(i) Specified in the MCO, PIHP or PAHP contract.

(ii) Based, at a minimum, on the number of providers in that specialty